LF 006930
CF

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER 0061992
2248191

TYPE/PRINT IN PERMANENT BLACK INK

FOR USE BY PHYSICIAN OR INSTITUTION

DECEDENT

1 DECEDENT'S NAME (First Middle Last): (b)(3):CPSA Section 25(c)
2 SEX: Male
3 DATE OF DEATH (Month Day Year): (b)(6)
4a AGE - Last Birthday (Years):
4b UNDER 1 YEAR: MONTHS 2 | DAYS 11
4c UNDER 1 DAY: HOURS | MINUTES
5 DATE OF BIRTH (Month Day Year): (b)(6)
6 COUNTY OF DEATH:
7a LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number): Final Grace Hospital
7b IF HOSP OR INST Inpatient Op /Emer Room DOA (Specify): EMER ROOM
7c CITY, VILLAGE, OR TOWNSHIP OF DEATH: Detroit
8 SOCIAL SECURITY NUMBER: (b)(3):CPSA Sec
9a USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Never Worked
9b KIND OF BUSINESS OR INDUSTRY:
10a CURRENT RESIDENCE - STATE: (b)(6)
10b COUNTY:
10c LOCALITY (Check one box and specify): [X] INSIDE CITY OR VILLAGE OF [ ] TWP OF Detroit
10d STREET AND NUMBER: (b)(6)
10e ZIP CODE: (b)(6)
11 BIRTHPLACE (City and State or Foreign Country):
12 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Never Married
13 SURVIVING SPOUSE (If wife, give name before first married):
14 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No): No
15 ANCESTRY - Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc (Specify below): African-American
16 RACE - American Indian, Black, White, etc If Asian, give nationality, i.e., Chinese, Filipino, Asian Indian, etc (Specify below): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): (b)(6)
19 MOTHER'S NAME (First, Middle, Surname before first married): (b)(6)

INFORMANT

20a INFORMANT'S NAME (Type/Print): (b)(6)
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, ZIP Code): (b)(6)

DISPOSITION

21 METHOD OF DISPOSITION - Burial, Cremation, Removal, Donation, Other (specify): Burial
22a PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place): (b)(6)
22b LOCATION - City or Village, State:
23 SIGNATURE OF FUNERAL SERVICE LICENSEE: (b)(6)
24 LICENSE NUMBER (of Licensee): 7067
25 NAME AND ADDRESS OF FACILITY: (b)(6) 27

CAUSE OF DEATH

26 PART I Enter the diseases, injuries, or complications that caused the death. Do NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a pending -POSITIONAL ASPHYXIA
Approximate Interval Between Onset and Death: UNKNOWN

Sequentially list conditions, IF ANY, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b DUE TO (OR AS A CONSEQUENCE OF):
c DUE TO (OR AS A CONSEQUENCE OF):
d AMENDED OCTOBER 6, 2003

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:
27a WAS AN AUTOPSY PERFORMED? (Yes or No): Yes
27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): Yes

CERTIFIER

28 ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify): Hospital
29 WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No): Yes

CERTIFYING PHYSICIAN
30a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title):
30b DATE SIGNED (Mo., Day, Yr.):
30c TIME OF DEATH: M
30d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):

MEDICAL EXAMINER
31a [ ] The case reviewed and determined not to be a medical examiner's case (Check one only) [X] On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated. (Signature and Title):
31b DATE SIGNED (Mo., Day, Yr.): (b)(6)
31c CASE NUMBER:
31d PRONOUNCED DEAD (Mo., Day, Yr.) ON Sep 29, 2003
31e TIME OF DEATH: 10:09am M

MEDICAL EXAMINER

32a NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type or Print): Leigh A. Hlavaty, M.D., Assistant Medical Examiner, 1300 E. Warren, Det., MI 48207
32b LICENSE NUMBER: (b)(6)

MEDICAL EXAMINER

33a ACC, SUICIDE, HOM., NATURAL OR PENDING INVEST. (Specify): ACCIDENT
33b DATE OF INJURY (Mo., Day, Yr.): SEPTEMBER 29, 2003
33c TIME OF INJURY: UNKNOWN M
33d DESCRIBE HOW INJURY OCCURRED: FACE DESTRUCTED BY CRIB BUMPER PAD
33e INJURY AT WORK (Specify Yes or No): NO
33f PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify): HOME
33g LOCATION - Street or R.F.D. No., City, Village or Twp., State: (b)(6)

34a REGISTRAR'S SIGNATURE: (b)(6)
34b DATE FILED (Month, Day, Year): OCT 01 2003

CH - 0483 10/98
(formerly B-36)